AUTO-ASSIGNMENT

The process of automatically assigning a beneficiary to a Medicaid Health Plan using a Michigan Department of Health and Human Services (MDHHS) approved algorithm. A beneficiary is auto assigned when s/he or the authorized representative does not voluntarily pick a health plan within the required period of time (approximately 22 to 28 calendar days).

BENEFICIARY

A person eligible for or receiving benefits under an insurance policy or plan, Medicare, or Medicaid program. This term is used by health and insurance staff and refers to the child in foster care.

BRIDGES

Eligibility system operated by MDHHS.

CARECONNECT360

CareConnect360 is a care management tool and Internet portal that is used by foster care and juvenile justice staff to access integrated physical and behavioral health-related information – along with other human services information about Medicaid (foster care and juvenile justice) beneficiaries.

CHAMPS

The Community Health Automated Medicaid Processing System (CHAMPS) is the web-based MDHHS claims processing system. The CHAMPS data system provides Medicaid related information including payments and beneficiary verification to providers and other authorized users.

CMH OR CMHSP

Abbreviation for Community Mental Health (CMH) or Community Mental Health Services Program (CMHSP). Each county has a local CMH program that provides supports and services to persons with mental illness, adults and children with developmental disabilities and children with serious emotional disturbances. For a description of CMH services for children, go to MDHHS website Adult & Children's Services/Foster Care/Fostering Mental Health.

COMMITMENT PERIOD (ALSO KNOWN AS LOCK IN)

Commitment period describes the period during which termination of the specific Medicaid Health Plan (MHP) enrollment is not possible. The MHP can be changed during the first 90 days of enrollment. After the child has been enrolled in his/her plan for more than 90 days, he/she is committed (locked in) to that specific MHP until the annual open enrollment period.

COPAYMENT (ALSO KNOWN AS CO-PAY)

A payment that beneficiaries must pay at the time of service. Fee-for-service Medicaid and some Medicaid Health Plans have co-pays for beneficiaries age 21 and older. One example is a one dollar ($1) co-pay for generic prescriptions.

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

A program, formerly known as the Crippled Children's Program, for children with chronic serious illness, disease or disability that requires extensive specialty care.

The program is available to all families regardless of income or health insurance. CSHCS assists with:

- Payment for specialty medical care needs.
- Arrangement for supplies and equipment.
- Referral to specialists and other community resources.
- Coordination of services.

CUT-OFF DATE

The date when an effective date of health plan enrollment would change. For example, an enrollment processed before cut-off is effective the first of the next month. A health plan enrollment processed after cut-off is effective the first of the next available month. Also known as card cut-off.

DURABLE MEDICAL EQUIPMENT (DME)

Term used to describe medical equipment prescribed by a medical provider and used in the home to aid in a better quality of living. DME may include but is not limited to the following: iron lungs, oxygen tents, hospital beds, wheelchairs, blood glucose monitors for diabetics, portable toilets, canes, lifts, and other similar equipment.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)

EPSDT is a Medicaid child health program of early and periodic screening, diagnosis, and treatment services for beneficiaries under the age of 21. It supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriate use of those resources. Detailed information is provided in FOM 801, Health Care Services for Children in Foster Care.

EFFECTIVE DATE OF ENROLLMENT

The date on which the coverage for a Medicaid Health Plan goes into effect. This is always on the first day of a month. Also called the enrollment begin or start date.

EXCEPTION TO MANAGED CARE ENROLLMENT

A process by which a Medicaid beneficiary can voluntarily request to remain in Fee-for-Service (FFS) Medicaid and not be required to join a Medicaid Health Plan. The caseworker contacts Michigan ENROLLS (1-888-367-6557) for the Medical Exception Request. MDHHS approves a medical exception in very limited situations. Also known as Medical Exception.

EXCLUDED ENROLLMENT STATUS

The enrollment status given to any Medicaid beneficiary who cannot enroll in a health plan. An example is beneficiaries who have both Medicaid and Medicare.

EX PARTE REVIEW

A determination made by the department without the involvement of the recipient, the recipient's parents, spouse, authorized representative, guardian, or other members of the recipient's household. A Medicaid ex parte review is based on a review of all materials available to the specialist that may be found in the recipient's current Medicaid eligibility case file.

FEE-FOR-SERVICE (FFS) MEDICAID

Also known as traditional, regular, or straight Medicaid. Medicaid pays the providers. FFS Medicaid screens for the services provided to FFS beneficiaries for medically necessary services. Beneficiaries age 21 and over have co-payments on certain services due at the time the services are provided. Beneficiaries with FFS are not enrolled in a Medicaid Health Plan and can see any provider that accepts Medicaid FFS.

HEALTH LIAISON OFFICER

The primary role of the MDHHS Health Liaison Officer (HLO) is to promote and ensure improved health outcomes for children in foster care. An HLO is allocated to all MDHHS foster care offices. The individual tasks related to the position can be found in FOM 801, Health Liaison Officer.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An HMO is a network of doctors, specialists, hospitals, pharmacies, and other ancillary providers that is licensed by the State of Michigan to provide health care services to enrolled members.

HIPAA

Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to protect a patient's health information and ensure accountability. Health plans, medical billing, and health care providers are subject to strict rules regarding the electronic transmission of information regarding a patient's health.

INFORMED CONSENT

An informed consent is consent for treatment, provided after an explanation from the prescribing clinician to the consenting party of the proposed treatment, expected outcomes, side effects, and risks. The DHS-1643, Psychotropic Medication Informed Consent, or the prescribing clinician's alternative consent form that contains all of the required elements of the DHS-1643 as determined by the Foster Care Psychotropic Medication Unit (FC-PMOU), must be used to document this discussion between the prescribing clinician and the consenting party, when psychotropic medications ae prescribed.

IN LOCO PARENTIS

Latin for in the place of a parent, refers to the legal responsibility of a person or organization to take on some of the functions and responsibilities of a parent.

LOCK IN

See Commitment Period.

MANAGED CARE

A health care delivery system that provides or makes arrangements for all medically necessary health services for its beneficiaries.

MANAGED CARE ORGANIZATION (MCO)

This refers to a Medicaid Health Plan. It is also known as a Medicaid Health Plan (MHP) or Health Maintenance Organization (HMO).

MANDATORY ENROLLMENT STATUS

An enrollment status given to a Medicaid beneficiary who must enroll in a Medicaid Health Plan.

MEDICAID HEALTH PLANS (MHP)

Managed care organizations providing for the delivery of comprehensive health care services to Medicaid enrollees in exchange for a fixed, prepaid sum without regard to the frequency, extent, or kind of health care services. Medicaid Health Plans provide a number of health care services to enrollees including, but not limited to: Early and Periodic Screening, Diagnosis and Treatment services, lead screening, office visits (such as well-child, routine and sick visits, school and sports physical exams and routine and preventative care), and outpatient behavioral health services for children and youth with mild to moderate emotional disturbance.

MEDICAID PROGRAM CODES

Medicaid Program Code	Program Description	Medicaid Health Plan Enrollment Status
E	Medicaid for disabled SSI recipients	Mandatory
O	Medicaid for the blind	Mandatory
B	Medicaid for the blind SSI recipients	Mandatory
L	MICH Care Medicaid and Medicaid for pregnant women	Mandatory
I	Refugee Assistance Program	Excluded
Q	Medicaid for persons under 21	Mandatory
N	Medicaid for caretaker relatives and families with dependent children	Mandatory
C	Aid to families with dependent children	Mandatory
P	Medicaid for the disabled	Mandatory

MEDICATION REVIEW

The evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing medicines for a patient.

MEDICARE

A federal health care program for the elderly or disabled. If a Medicaid beneficiary also has Medicare, s/he has an excluded enrollment status from Medicaid Health Plans.

MI ENROLLS

Michigan Enrolls (MI Enrolls) is the state's contracted enrollment broker through MDHHS. Medicaid Health Plan enrollment activity is facilitated through MI Enrolls.

OPEN ENROLLMENT

The month during which a beneficiary enrolled in an MHP is given the opportunity to change to a different plan. An open enrollment for MHP beneficiaries occurs annually.

PARTICIPATING PROVIDER (ALSO KNOWN AS A PAR PROVIDER)

A provider who is credentialed and contracted with a Medicaid Health Plan to provide services to that plan's members.

PHARMACIES

Medicaid Health Plans have very complete pharmacy networks and most contract with all major pharmacy chains. Check the Medicaid Health Plan web sites for details or ask local pharmacies which Medicaid Health Plans are accepted.

PIHP

Acronym for Prepaid Inpatient Health Plan which is an organization that is responsible for managing Medicaid services related to behavioral health and developmental disabilities typically delivered by the Community Mental Health Services Programs (CMHSPs).

PRIMARY CARE PHYSICIAN (PCP)

This is the term for a doctor that is responsible for a beneficiary's basic medical care. MHP beneficiaries must work with their PCP for all their health care needs, including specialty services. A primary care provider may be a family or general practitioner, an internist, a pediatrician, or sometimes an OB/GYN. MI Enrolls can help find a PCP during the MHP call-in enrollment process. Also known as primary care provider.

PRIOR AUTHORIZATION (PA)

For some services, Medicaid FFS or a Medicaid Health Plan requires providers to obtain prior approval before payment is made for a service. Examples of services that may require a PA include prescriptions or medical equipment. The provider is the only one who can request a prior authorization; see definition to provider in this item.

PROTECTED HEALTH INFORMATION (PHI)

Protected health information (PHI), also referred to as personal health information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule provides federal protections for protected/personal health information (PHI) held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

PROSPECTIVE

In the future.

PROVIDER

An individual or organization enrolled in the Medicaid program that provides services or supplies to beneficiaries, or an individual or

organization that is credentialed and contracted with a Medicaid Health Plan. A provider may be a primary care physician (PCP), outpatient clinic, specialist, hospital, urgent care, durable medical equipment (DME) provider, or Medicaid Health Plan.

Note: Some providers who contract with Medicaid Health Plans are not Medicaid enrolled providers. Beneficiaries can only go to non-Medicaid providers if they are enrolled in a plan that participates with that provider.

PROVIDER NETWORK

Medicaid Health Plans have a network of providers including, but not limited: to primary care physicians, specialists, pharmacies, hospitals, labs, durable medical equipment providers (DMEs), and outpatient clinics. Check the Medicaid Health Plan web sites for provider network information.

REFERRAL

The process of sending a patient from one practitioner to another for health care services. Medicaid Health Plans (MHPs) may require that designated primary care providers authorize a referral for coverage of specialty services. Normally, this type of referral means a written order from the enrollee's primary care doctor for the enrollee to see a specialist or get certain services. In many HMOs or MHPs, a referral must be made before the enrollee can obtain care from anyone except the primary care doctor. Without a formal referral, the plan may not pay for the care; see *primary care physician* in this item.

RE-ENROLLMENT

When a Medicaid beneficiary loses eligibility, or when a case number changes, that beneficiary’s enrollment in the Medicaid Health Plan is ended. If the beneficiary regains Medicaid eligibility within 60 days (includes case number changes), MI Enrolls will automatically re-enroll the beneficiary in the Medicaid Health Plan for the next available month. MI Enrolls mails a letter telling the beneficiary (or the authorized representative) about the re-enrollment, including the effective date.

REMINDER LIST

The list of children within foster care who have not enrolled in a Medicaid Health Plan and will be auto assigned if a preferred choice is not made soon. A designated MDHHS point of contact receives the statewide list electronically on a weekly basis. A child name will only appear once on a list and will not be included on subsequent reports if the auto assignment has not been processed the following week.

ROUTINE MEDICAL CARE

See Routine, Non-surgical Medical Care Defined in FOM 801, Health Services for Foster Children.

SED

An acronym for Serious Emotional Disturbance (SED), and as defined by the Michigan Association of Children's Mental Health SED is a diagnosable mental, behavioral or emotional disorder affecting a child that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM). The child's condition must result in functional impairment that substantially interferes with or limits his/her functioning in family, school, or community activities.

THIRD PARTY LIABILITY (TPL)

A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a Medicaid beneficiary under the approved state Medicaid plan.

Federal law and regulations require states to ensure Medicaid beneficiaries use all other resources available to them to pay for all or part of their medical care before turning to Medicaid. The State Medicaid program pays only after the third party has met its legal obligation to pay.

VOLUNTARY ENROLLMENT STATUS

An enrollment status given to a beneficiary who may either enroll in a Medicaid Health Plan or in fee-for-service Medicaid. Voluntary beneficiaries may disenroll from any health plan at any time upon request. Examples of beneficiaries with a voluntary enrollment status are American Indians and migrants.